

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034451

FILED VS  
ENDED

SEP 26 1960

128

Primary Registration District No. 2450

Registrar's No. 953A

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>STONE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>5hrs</b>	c. CITY OR TOWN <b>CRANE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST: JOHNS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>PENLAND</b> Last <b>PENLAND</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>13</b> Year <b>1960</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/4/1908</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>BARRY CO, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Smyth</b>		13b. MOTHER'S MAIDEN NAME <b>CLARA GARNER</b>		14. NAME OF HUSBAND OR WIFE <b>CLYDE PENLAND</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>MRS CLARA SMYTH CRANE, MO</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory paralysis 2 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>suicidal ingestion of nicotine (Black Leaf 40)</b>		<b>4 hours</b>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Springfield</b>	COUNTY <b>MO</b>	STATE <b>MO</b>
21. I attended the deceased from <b>13 Sept 1960</b> to <b>13 Sept 60</b> and last saw him alive on <b>13 Sept 1960</b> . Death occurred at <b>2:05 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Francis Manlove MD</b>	(Name or title)	22b. ADDRESS <b>Springfield, MO</b>	22c. DATE SIGNED <b>16 Sept 60</b>
23a. BURIAL, CREMATION, REMOVAL <b>REMOVAL</b>	23b. DATE <b>9/13/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local Crane Missouri</b>	23d. LOCATION (City, town, or county) <b>Crane Missouri</b>

24. FUNERAL DIRECTOR <b>MANLOVE FUNERAL HOME, CRANE, MO</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-19-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 26 1968

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Gene C. Hinkle*

Licensed Embalmer No. 473

P. O. Address Spfld. Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.